General Practitioner, Dr B

A Report by the

Health and Disability Commissioner

(Case 01HDC00389)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Parties involved

Mrs A	Consumer
Dr B	General Practitioner
Dr C	Obstetrician and Gynaecologist
Mrs D	Consumer's friend
Dr E	General Practitioner

Complaint

On 6 January 2001 the Commissioner received a complaint from Mrs A about the standard of care she received from Dr B, general practitioner. The complaint is summarised as follows:

- *On 11 August 2000, Mrs A visited Dr B for her annual vault smear. Dr B did not examine Mrs A's abdomen for lumps, although she told him she still had her ovaries.*
- *Mrs A returned to Dr B on 13 October 2000, after noticing a lump in her left lower abdomen. Dr B incorrectly informed Mrs A that the lump was a sebaceous cyst in her abdominoplasty scar.*
- *Mrs A returned to Dr B on 7 November 2000, with a distended abdomen and breathlessness. Dr B incorrectly informed Mrs A that she was bloated and should eat bran, and incorrectly attributed her breathing problems to asthma.*
- *Mrs A returned to Dr B on 17 November with an uncomfortable, bloated abdomen akin to a five-month pregnancy. Dr B suggested Xenical and liposuction as the remedy, without examining Mrs A.*
- *Dr B did not adequately examine Mrs A, did not diagnose ascites, and did not refer for further tests or assessment on any of the above occasions.*

An investigation was commenced on 7 February 2001.

Information reviewed

- Mrs A's clinical records from a medical centre and a public hospital
- Independent expert advice from Dr Jim Vause, general practitioner

Information gathered during investigation

Background
Mrs A had a hysterectomy in 1986, and was advised by her surgeon that she would require an annual vaginal vault smear examination as follow-up.

Mrs A transferred her medical care to Dr B at a medical centre in early 1999. On 11 August 2000, Mrs A consulted Dr B for her annual vault examination.

Mrs A said that Dr B used a vaginal speculum to obtain the vault smear but did not examine her further. She said that during the procedure to obtain the smear Dr B remarked that she had a polyp in the vaginal vault. Mrs A recalled that Dr B said he would refer her to a gynaecologist for an assessment of the polyp and asked if she had any preferences in relation to gynaecologists. He said that he would also speak to Dr C, gynaecologist, about treatment options for the condition.

Dr B disputed Mrs A's recollection of the consultation. He informed me that the smear was performed without problem, and that "no abnormalities (including no polyp) was seen". The clinical records for Mrs A for 11 August 2000 record that her oesophageal reflux was "better but not 100%". Dr B recorded her heart rate, blood pressure and weight, and noted that her chest sounds were normal. He gave her repeat prescriptions for Cardoxan and Inhibace (heart medication) for a further 90 days and Losec (reflux medication) for 30 days. Dr B informed me that a subsequent laboratory report on the vault smear confirmed a normal result and there was no indication for a referral.

Mrs A informed me that she spoke to Dr C the same day. (Mrs A is Dr C's secretary.) Dr C told her not to worry about the polyp unless she was bleeding and recommended that she consult a second gynaecologist.

Dr C informed me that he has no recollection of this conversation, but said that if it did take place he would have given advice along the lines of, "You should see …" He said that had Mrs A consulted him in a professional capacity about this matter he would have been quite definite as he always keeps detailed notes.

Mrs A said that she telephoned the medical centre on 13 August and spoke to the practice secretary to nominate the second gynaecologist as her preferred gynaecologist. She assumed that the practice secretary would send a referral letter to the second gynaecologist. There is no record in Mrs A's notes to indicate that a referral to a gynaecologist was made or that the information was recorded.

Dr B informed me that the medical centre does not give their patients referral letters. He said that it is their practice that "all referrals are faxed directly from the computer by our receptionist. This provides an automatic copy in the notes. To avoid any confusion with appointment times patients are asked to make their own booking."

Dr B said that Mrs A's next visit to the surgery was on 13 October. She was complaining of a recurrence of her reflux oesophagitis. Dr B said that he prescribed her further

medication for the condition and told her that if the problem did not resolve he would refer her for a gastroscopy (examination of the stomach).

Mrs A recalls informing Dr B that she had a lump in the left lower pelvic area. She stood and raised her clothing and showed him the lump. Dr B told her that she did not have a lump in the pelvic area. Rather there appeared to be an epidermal cyst on the surface of the skin adjacent to an abdominal scar.

Dr B recalled that he suggested to Mrs A that an ultrasound examination of the area would be helpful. He intended the ultrasound to detect what was in the immediate environs of the cyst. He said that when he took out a radiology referral form, Mrs A informed him that she could arrange for this to be done at the clinic next to where she worked.

Dr B said that he left Mrs A to arrange the ultrasound and, because this was unusual, he recorded in his notes: "u/s [ultrasound] to view below cyst (TBA [to be arranged] self in own practice)".

Mrs A informed me that she deeply lacerated her leg in a fall on the evening of 13 October, before she could arrange the ultrasound. As a result of the fall, she was admitted to the public hospital for three days and received intravenous antibiotics. She said that the fall immobilised her for three weeks, and that during this time she noticed that her abdomen was becoming distended. She presented at Dr B's surgery on 18 October to uplift ACC forms in relation to her leg injury. She was in a wheelchair at the time, with her left leg elevated.

Mrs A saw Dr B again on 7 November. She told him that she was concerned about her abdominal distension and that she was also having difficulty breathing. She recalled that Dr B told her that the abdominal distension was due to "bloating" and he advised her to eat bran. Mrs A told Dr B that she was on a diet organised by Mrs D, a friend who was a dietician. She further told him that she was full of wind and was unable to do up her skirt.

Mrs D informed me that she stayed with Mrs A for about a month at this time. She said that she was cooking most of their meals and had noticed that although Mrs A was eating little she did not appear to be losing any weight. Mrs D said that Mrs A's stomach was "noticeable". She said she was unable to recall Mrs A doing anything special about her diet or eating bran.

Dr B informed me that when he recorded Mrs A's Peak Respiratory Flow Rate (PRFR, a measure of lung function) on 7 November to ascertain why she was having difficulty breathing, he found that she scored 320L/min. (Normal for her age and weight is 480L/min. Mrs A's PRFR taken on 27 April 2000 was 500L/min.) A chest examination revealed widespread rhonchi (wheezing sounds caused by narrowed airways) and, as there were no fluid sounds in her chest, Dr B diagnosed asthma. He prescribed Mrs A a two-week course of prednisone and gave her a further course of medication for her oesophageal reflux, informing her that the prednisone was likely to aggravate this condition. Dr B informed me that he had no recollection of discussing abdominal distension or advising Mrs A to eat bran, and did not record this in the clinical records.

Mrs A consulted Dr B again on 17 November as she was concerned that she had gained a considerable amount of weight and that her abdomen was further distended. She recalled that her abdomen was swollen to the size of a five-month pregnancy, and the extent of her bloating was confirmed by her father.

Dr B's records show that the primary reason for Mrs A's visit on 17 November was because she was concerned about discomfort in the lateral aspect of her right thigh. Dr B was unable to detect any abnormality. His impression was that the discomfort was associated with her fall on 13 October or a problem with her lumbar spine. He recommended a short trial of anti-inflammatories. Dr B also noted that she was worried about her weight gain. He recorded her weight as 90kg, a 3kg increase since August. He considered that this could be accounted for by her three weeks of immobility following the accident, and the recent course of prednisone. He advised her to discontinue the Premarin (hormone replacement), to increase her exercise and possibly consider Xenical weight control tablets. Dr B did not examine Mrs A's abdomen as he thought there was no indication for this.

Mrs A informed me that she consulted Dr E, general practitioner, on 24 November for a second opinion, as she continued to be concerned about the distension. Dr E recorded that Mrs A had felt well prior to her fall and that since then had been "feeling like death". Mrs A told Dr E that she "felt something was wrong with her ovaries 8 weeks ago". Dr E ordered blood tests and referred Mrs A for an abdominal ultrasound examination.

Dr E telephoned Mrs A to inform her that the ultrasound showed that she had cancer of the ovary. Mrs A was referred for surgery, which was performed by a surgeon and Dr C at a public hospital on 28 November. Mrs A was referred for chemotherapy following the surgery.

Dr B was informed of Mrs A's condition when he was asked to forward her clinical records to Dr E on 27 November. He immediately telephoned Mrs A, and said: "Please accept my sincerest apologies for not making this diagnosis."

Independent advice to Commissioner

The following expert advice was obtained from an independent general practitioner, Dr Jim Vause:

"Thank you for your request to appraise and give opinion on the matter of [Mrs A's] medical care from [Dr B].

I have perused the following documents provided by your office:

- Complaint letter from [Mrs A] marked 'A'.
- Two action notes dated 2 February 2001, of conversations with [Mrs A] in order to further clarify her complaint, marked 'B'.
- Investigation letter to [Dr B] marked 'C'.
- Response from [Dr B] with consultation notes enclosed, marked 'D'.
- Copies of medical records for [Mrs A] held by [Dr E], marked 'E'.
- Action note of telephone conversation with [Dr C] dated 7 May 2001, marked 'F'.
- Copy of letter dated 14 August 2001, with returned interview transcript from [Mrs A], marked 'G'.
- Letter dated 16 November 2001 from [Dr B], with signed interview transcript, marked 'H'.

On the matter of potential conflicts of interest, I know neither [Mrs A] nor [Dr B], nor any of the other persons referred to in the notes and summaries.

In direct reply to your questions

- *Were each of [Dr B's] examinations of [Mrs A] on 11 August 2000, 13 October 2000, 7 November 2000 and 17 November 2000, appropriate and complete?*

    1. The examination on the 11 August 2000 was, on the basis of the presenting problem as recorded by [Dr B], adequate. However given that [Mrs A] had first presented with 'reflux oesophagitis' on 26-05-2000, an abdominal examination would have been prudent either on that first occasion or on August 11. This was [Mrs A's] first such presentation with 'reflux oesophagitis' and a GP should consider other possible causes for her symptoms. It is unfortunate that [Dr B's] notes do not record the nature of [Mrs A's] symptoms, nor any examination, merely the diagnosis.

    2. 13 October. There is [a] recording in [Dr B's] notes of a 'surface epidermal cyst'. However there is no recording of other abdominal or pelvic examination findings, be they positive or negative. [Mrs A's] letter of 29-12-2000 indicates that the examination was not ideal ('with me standing beside him in the surgery') and [Dr B's] letter 'D' confirms this. The correct method is to have the patient supine on an examination table.

3. I note that [Dr B] requested an ultrasound investigation at this time, which suggests that either he or [Mrs A] did not fully accept that the 'surface epidermal cyst' was the cause of [Mrs A's] symptoms. If such an investigation were considered, it would be appropriate that an abdominal or pelvic examination was performed.

4. 7 November: The examination findings are those of a chest examination. These are adequate and appropriate for the recorded symptom presentation. There is no record of abdominal examination findings but neither is there record of abdominal symptomatology in [Dr B's] notes.

5. 17 November. [Mrs A] presents two problems, namely right thigh discomfort and weight gain since her accident: [Dr B] records examining her thigh and her back, specifically her lumbar spine. In addition he recorded her weight. While this appears adequate, given [Mrs A's] problems I would feel a little uneasy without checking her out more comprehensively, especially for conditions such as venous thrombosis, given her recent injury. However the symptoms do not give clear indication for pelvic abnormality.

- *For each of the above consultations, were [Dr B's] examination findings reasonable on the basis of the information that was available to him at the time?*

His findings appear adequate with the qualifications given above.

- *In your opinion, did [Dr B] take adequate note of what had occurred at the previous consultations during his later consultations with [Mrs A]?*

I can only judge this from his clinical notes and it appears to me he did so EXCEPT for his failure to follow up on the non performed pelvic ultrasound scan.

- *Please advise whether you would normally expect an abdominal examination to be performed during a routine, recall vault smear if the ovaries were still present.*

No. This is a somewhat contentious issue but considering that a vault smear is a screening procedure ie performed on asymptomatic women, then there are a large number of issues such as specificity and sensitivity of a screening procedure to be considered. To conduct further examination on a woman without symptoms raises the possibility of a false positive finding causing adverse impact on patient wellbeing through further investigation and worry, or false reassurance through a false negative finding on the examination. (A false positive is where an abnormality is found on examination but that abnormality on subsequent investigation is found to be of no significance. A false negative is where there is no abnormality found on examination but there is in fact an underlying pathology of significance that was not detected.)

Informed consent is also an important issue when proceeding on to perform an invasive examination on an asymptomatic person.

I have conducted a straw poll of the Council of the RNZCGP on this issue and approximately ½ of the 8 respondents perform routine pelvic examinations under these circumstances and ½ do not. A quick review of the medical literature produced the follow[ing] summary of the scientific evidence from Bandolier, a high quality evidence summary organisation. The subject was a review of possible methods for the early detection of ovarian cancer.

'Screening tests available

There is a general consensus that pelvic examination, tumour markers, and ultrasound examination form the three most likely candidates for a screening programme. Pelvic examination is particularly poor in screening for ovarian cancer and there is little to recommend it'. (Underlining added)

http://www.jr2.ox.ac.uk/bandolier/band16/b16-6.html

In consideration of this, [Mrs A's] comments in 'B' that

'Her understanding is that as part of a normal vaginal examination, the doctor should feel around the ovaries to make sure there isn't a lump'.

[Mrs A] was an employee of [Dr C], a gynaecologist, for who such a standard of care MAY be appropriate. This poses an interesting conflict between a professional standard based on opinion consensus and a standard based on evidence. I would regard the evidence, applied correctly as being more appropriate.

In considering the claim of [Mrs A] that [Dr B] found a vaginal polyp when performing a vault smear, further examination at that time may have been appropriate depending on the size, location and appearance of the polyp, especially as [Mrs A] had previously had a hysterectomy for an abnormal smear. However, [Dr B's] notes do not indicate finding any such polyp, thus negating this argument.

Thus I believe [Dr B's] examination at the routine vault smear to be appropriate.

- *In your opinion, how long was ascites likely to have been present for? Is there any evidence to indicate that [Dr B] should have diagnosed ascites earlier? If so, when?*

Diagnosis of a condition such as ascites is not easy, especially if it is early or mild. It requires a high index of suspicion based on the patient history and a good examination of her abdomen. Clinical signs are notoriously unreliable and difficult to interpret. Useful information on this may be found at http://www.jr2.ox.ac.uk/bandolier/band66/b66-7.html.

Irrespective of the ascites issue, if [Dr B] had examined [Mrs A's] abdomen in her later presentations to him, I believe he would have found either ascites or the pelvic masses. On the 24-11-00 these pelvic masses were significant 10.7x7.9x7.2cm on the right and

6.2x6.7x4.8cm on the left. [Mrs A] obviously could detect these, as should have a doctor on appropriate abdominal examination.

A confounding finding is that [Dr E] makes no comment in her notes on the detection of ascites during her clinical examination of [Mrs A] on 24 November, one week after [Mrs A's] last visit to [Dr B]. Neither could I find any record of clinical examination finding in the specialist letter. It is possible that [Mrs A's] ascites had deteriorated significantly between 17 November and the 24th.

- *In your opinion, on the basis of the information that was available at the time, should [Dr B] have referred [Mrs A] for further tests or assessments following any of his consultations with her? If so, when?*

This is very difficult to assess due to the dissonance between [Mrs A's] account and [Dr B's] records.

On the basis of [Dr B's] records, I feel that the ultrasound scan request was appropriate. This is the only clear indication for referral. He also appropriately considered referral if her reflux had failed to improve with the Somac tablets he prescribed (13 October).

Otherwise, [Dr B] did not have any pointers indicating that referral was necessary.

By contrast, [Mrs A's] account of the events following her injury give description of symptoms that should have resulted in abdominal examination on 17 November at least, and further investigations dependent on examination findings.

- *Please also comment on any additional relevant matter which you think should be brought to the Commissioner's attention.*

Dissonance:

The dissonance between patient described symptoms and the doctor notes are significant, but not unusual. It is important for a doctor, especially a GP, to establish a patient's 'agenda', that is their list of complaints and their expectations of the consultation. This can be difficult to elicit from a patient and time constraints can play a significant part in preventing establishing good patient doctor communication. However it appears that the patient's symptoms were not adequately explored, especially the abdominal bloating in the later consultations.

Clinical notes

The question arises as to whether the notes truly reflect the consultations. Good recording of symptoms in a doctor's notes reflects the appropriateness of this process. [Dr B] records his examination findings adequately but his quality of patient symptom recording is less. It is possible that this reflects either inadequate exploration of the patient symptoms or inadequate recording.

Comparison on recording of patient's symptoms may be made between [Dr B's] 17 November notes and [Dr E's] 24 Nov notes.

SUMMARY

Examination:

In my opinion

- Pelvic examination was NOT indicated at the 11 August routine smear consultation.
- An adequate abdominal/pelvic examination should have been carried out when [Mrs A] indicated on 13 October that she had a lump in the pelvic area. This need is supported by the ultrasound scan request.
- [Dr B] should have examined [Mrs A's] abdomen for her earlier presentation with reflux oesophagitis. However I do not think he would have found her ovarian cancer.

Scan follow up:

The lack of follow up of the scan request from 13 October is a concern and again highlights the importance of test result follow up, in this case for a problem which [Dr B] did not feel was indicative of a cancer. It appears [Dr B] did not identify the need for follow up during his subsequent consultations with [Mrs A] and it would be useful to identify any reasons for this such as the accessibility of notes, locations of computer terminals etc.

Exploration of patient symptoms.

I suspect this is a key issue in this case, and is likely to involve both doctor and patient factors. This is not unusual in medicine and is a factor of which practitioners need to maintain a high level of awareness."

Response to provisional opinion

In response to my provisional opinion, Dr B stated:

"Thank you for your letter of 13 August 2002 and your provisional opinion, and the invitation to respond in order to clarify or dispute the information and the conclusions.

There has been no breach of the New Zealand Medical Association 'Code of Ethics' (1989) for the following reasons:

- There was no indication for an abdominal/pelvic examination on 13 October. There was a request to look at a skin lesion on the lower abdominal wall. This was viewed with the patient standing. It was a skin lesion described as a surface epidermal cyst (which was adjacent to an abdominoplasty scar). It was not a lump in the pelvis. It is entirely appropriate to examine any skin lesion with the patient standing. Dr Vause has commented that an abdominal examination should be conducted with the patient lying supine. It is misleading to take this comment and apply it to the examination of a skin lesion.

- The ultrasound investigation was suggested to more fully examine and assess the extent of the cyst. It was not requested to view the pelvis. There was no indication at that time to investigate the pelvis. It is common practice to ultrasound abdominal wall lesions such as cysts and lipomas (collections of fatty tissue) to confirm the cystic nature and the extent of the lesion. Dr Vause concluded that the request for an ultrasound implied there was a need for an abdominal or pelvic examination. This is simply incorrect. Again there was no indication to perform such an examination to assess a surface cyst and in fact some people might consider doing so inappropriate.

- For each of the consultations on 13 October, 7 November and 17 November there was a thorough examination of the presenting symptoms and accurate records were kept. It is inaccurate to state … that '... [the patient] returned to see [Dr B] on 13 October when she had noticed a lump …' The presenting symptom was one of oesophageal reflux discomfort. The symptoms and a management plan were discussed including the use of treatment that had been prescribed previously and a follow-up arrangement to refer for the appropriate investigation (gastroscopy) if the symptoms did not settle. On 7 November and 17 November the presenting symptoms (chest problems and thigh discomfort respectively) were discussed, the appropriate examinations performed and a plan of management implemented in a logical manner to follow the findings. Of course with the benefit of hindsight I would have wanted to examine the abdomen and pelvis on 17 November, but the presenting symptoms simply did not reveal an indication.

In summary therefore I disagree that there has been a breach in the New Zealand Medical Association Code of Ethics. The consultations were conducted with care and skill in compliance with professional standards and accurate records of fact have been kept. I request that you review your opinion and confirm that there has been no breach of the Code."

Further independent advice

Dr B's full response was forwarded to my expert advisor to review. Dr Vause provided the following additional advice in October 2002:

"Thank you for your request for comments on [Dr B's] reply.

In his clinical notes, [Dr B] records the presentation of a 'L pelvic area lump' and his observation that this was a 'surface epidermal cyst'. There is also his plan to 'u/s (ultrasound) to view below cyst (TBA self in own practice)'.

[Dr B's] comments in the letter of 23 August that the cyst was adjacent to an abdominoplasty scar appear to be his personal recollection. This is not recorded in his clinical records.

On the matter raised in [Dr B's] examination of [Mrs A] on 13 October 2000:-

I have conducted a poll of my colleagues on the Council of the RNZCGP seeking opinion as to how a GP would be expected to examine a patient presenting with this type of lesion, and also whether they felt ultrasound examination was appropriate. There was no identification of the doctor, patient or locality and only the clinical note information from the consultation in question and patient characteristics were given. Long term outcome was not given.

The replies were varied with some doctors feeling the patient should be examined lying down, to exclude other pathology. Others felt that an erect examination was appropriate to exclude problems such as hernias. Many commented that the clinical information given in the notes was inadequate to make a satisfactory assessment of the clinical situation. However the information needs for an assessment of doctor performance such as in this case are different from the clinical needs for a doctor. Indeed, comprehensive recording of clinical information can be difficult if a patient presents with a number of problems in the space of an average GP consultation.

I would observe that if [Dr B] had found a cyst and [Mrs A] had agreed that this was the lump, then there was no clear need for further examination. Alas [Mrs A's] comments in her letters and interviews strongly suggest otherwise.

'This didn't gel with me. I have had problems with sebaceous cysts for years and they were always on or near the surface.'

Viewing the case in retrospect unfairly biases the judgment of a doctor performance. In a clinical situation, the subsequent history of the 'cyst' would provide further information. This raises the issue of follow up of this cyst of which there appears to be none. Did the lump settle, did it stay, did it enlarge? It may well have been a cyst, it may have been a solid lesion and indeed could have been a secondary from [Mrs A's] cancer.

Thus while the judgment of the adequacy of the examination on this occasion is not easy, the comments of [Mrs A] point towards a need for further examination and follow-up by [Dr B].

On the matter of the ultrasound examination:-

Initially I interpreted from [Dr B's] notes that the word 'below' referred to [Dr B's] intention to ultrasound the area below the cyst, i.e. [Mrs A's] pelvic area and NOT the cyst itself. This would indicate [Dr B] felt a need to exclude other pathology and pelvic ultrasound would be appropriate for this.

In review, I considered that the 'below' may have referred to the location of the word 'cyst' in the computerised clinical records, in that it appeared 'below' the line of [Dr B's] management plan. Unfortunately, the structure of the notes' print out as I received them does not favour this interpretation. The structure on computer may be different in the Practice Management System that [Dr B] uses. This PMS system has not been identified.

There may be other interpretations of the importance of this word but I cannot fit them with the clinical situation.

I suspect that [Mrs A's] concerns (as per her letter and interview) may have also led [Dr B] to request an ultrasound scan. As this was to be arranged by [Mrs A], the request form which should have provided good information on [Dr B's] suspicion was not used.

The choice to further investigate using ultrasound was variable in the group I polled. It could not be the 'common practice' [Dr B] stated. A few GPs commented that if there was any doubt as to the nature of the lesion, a fine needle aspirate or biopsy would be the most appropriate. However, from discussion with a radiologist, ultrasound clearly has a place for examining of lumps and the availability of such an investigation and the patient's ability to fund it would influence a GP's choice for this investigation.

Thus I would accept [Dr B's] comments that ultrasound of purely an abdominal/pelvic wall lesion was appropriate EXCEPT for the fact that the use of the word 'below' in [Dr B's] clinical notes suggests that he was considering more than the cyst.

The fact that the test, left to the patient's implementation, was not performed because of [Mrs A's] fall again flags the need for GPs to have a system to audit whether tests requested have been performed. Such systems can be implemented in computerised clinical notes and while they are not 100% effective, their use does enhance follow up of patient test results and reduces the chance of missed tests.

On [Dr B's] bullet point three

I have no debate except as above on the 13 October presentation.

In summary, after considering [Dr B's] reply,

- The lack of an abdominal examination remains of concern, especially with [Mrs A's] comments.
- The ultrasound request may not have indicated a concern for underlying pathology EXCEPT for the use of the word 'below' in [Dr B's] notes. This is in need of clarification.
- The lack of follow up of the ultrasound request needs addressing."

Code of Health and Disability Services Consumers' Rights

The following Rights in the Code of Health and Disability Services Consumers' Rights are applicable to this complaint:

RIGHT 4
Right to Services of an Appropriate Standard

1) Every consumer has the right to have services provided with reasonable care and skill.

2) Every consumer has the right to have services provided that comply with legal, professional, ethical, and other relevant standards.

Other standards

New Zealand Medical Association 'Code of Ethics' (1989)

Standard of Care

…

3. Ensure that every patient receives a complete and thorough examination into their complaint or condition.

4. Ensure that accurate records of fact are kept.

Opinion: Breach – Dr B

In my opinion Dr B breached Rights 4(1) and 4(2) of the Code in the course of providing medical services to Mrs A. These provisions are supported by the statements in the New Zealand Medical Association 'Code of Ethics' (1989) that individual doctors "ensure that every patient receives a complete and thorough examination into their complaint or condition" and that "accurate records of fact are kept".

13 October
Mrs A returned to see Dr B on 13 October. The presenting symptom was oesophageal reflux discomfort. Mrs A also informed Dr B that she had noticed a lump in the left lower area of her abdomen.

Dr B recorded in the clinical records for this visit that Mrs A was complaining of a recurrence of oesophageal reflux. He prescribed further medication for this condition and told her that if her symptoms did not settle he would refer her for a gastroscopy. He also noted that she showed him the lump in her abdomen.

Both Mrs A and Dr B agree that she stood while he examined the lump. My expert advised that this examination was not ideal, and that the correct method is for the patient to be supine on an examination table.

My general practitioner expert advised that opinion is divided about the appropriate examination of an abdominal sebaceous cyst. A supine examination is appropriate to exclude abnormal abdominal and pelvic anatomy, while an examination when standing is useful to exclude problems such as hernia. My expert noted that although Dr B stated that he had found a surface epidermal cyst, Mrs A disagreed: "I have had problems with sebaceous cysts for years and they were always on or near the surface."

My expert commented that dissonance between patient-described symptoms and the doctor's notes is not unusual.

I accept my expert's advice that despite Dr B's belief that he was examining a sebaceous cyst on 13 October, it would have been appropriate for him to perform an abdominal/pelvic examination at that time.

Follow-up of referral for further tests
On 13 October 2000 Mrs A mentioned to Dr B, as one of the conditions she was concerned about at that time, that she had discovered a lump in the region of her abdominal scar. Dr B suggested to her that an ultrasound examination would be helpful. When Dr B began to fill out a radiology referral form for an ultrasound examination, Mrs A informed him that she would organise this herself at the clinic next to where she worked. Dr B informed me that it was not his usual practice to have a patient arrange her own ultrasound. Dr B recorded in his notes: "O/e surface epidermal cyst. U/s to view below cyst (TBA self in own practice)."

My general practitioner expert advised that he had initially interpreted Dr B's note of "below" to mean that it was his intention to ultrasound Mrs A's pelvis in the area below the

cyst, to exclude other pathology. He noted Dr B's comments, in his response to the provisional opinion, that it was his intent to "more fully examine and assess the extent of the cyst" only, and agreed that the request for further examination of the cyst was appropriate.

Mrs A suffered an accident later that day and required admission to hospital for three days. As a result she did not arrange the ultrasound. Dr B did not follow this up on 18 October, 7 November or 17 November. My expert commented that Dr B did not identify the need to follow up the ultrasound referral during his subsequent consultations with Mrs A. My expert said that the fact that the test, which Dr B allowed Mrs A to organise, did not take place "flags the need for GPs to have a system to audit whether tests requested have been performed".

In my opinion, in failing to perform an abdominal examination on 13 October, and follow up the ultrasound examination referral, Dr B did not treat Mrs A with reasonable care and skill, and in compliance with relevant professional standards, and therefore breached Rights 4(1) and 4(2) of the Code.

Opinion: No breach – Dr B

In my opinion Dr B did not breach Rights 4(1) and 4(2) of the Code of Health and Disability Services Consumers' Rights in relation to his examinations of Mrs A on 11 August, and 7 and 17 November 2000, and his failure to diagnose ascites.

11 August
Mrs A saw Dr B on 11 August 2000 for a routine vaginal vault smear examination. Mrs A recalled that during the course of the examination, Dr B remarked that she had a polyp in the vaginal vault, and that he would refer her to the gynaecologist of her preference for further assessment. Dr B disputes this information. He informed me that he found no abnormalities when he performed this examination and smear and his records made at the time support this. There is no record on Mrs A's file that a referral to a gynaecologist was made.

Mrs A was concerned that Dr B did not physically examine her abdomen for lumps during this visit. My expert stated that if a vaginal polyp had been present then, depending on the size, location and appearance of the polyp, further examination at that time may have been appropriate. I am unable to establish whether Mrs A did have a vaginal polyp when Dr B examined her on 11 August or that Dr B considered referral to a gynaecologist in relation to this matter.

My independent general practitioner advisor stated that "pelvic examination is particularly poor in screening for ovarian cancer and there is little to recommend it". I accept my expert advice that pelvic examination was not indicated at the routine smear consultation and that Dr B's examination of Mrs A on 11 August was appropriate.

7 November
On 7 November Mrs A consulted Dr B with her concerns about shortness of breath and abdominal distension. Dr B's examination findings relate to his examination of Mrs A's chest. I am advised that this examination was adequate and appropriate for the recorded symptom presentation. There is no record of an abdominal examination or of Mrs A reporting any concerns about her abdomen. There is dissonance between Mrs A's recollection of what she told Dr B, and Dr B's records, and I am unable to establish whether there were grounds to indicate that Dr B should have investigated Mrs A's abdomen further at this visit.

17 November
Mrs A recalled that when she consulted Dr B again on 17 November, she was concerned about her weight gain and abdominal distension. Dr B's records indicate that her primary concern was discomfort in the lateral aspect of her right thigh. Dr B examined Mrs A in relation to this complaint. He was unable to find any obvious reason for the discomfort but in light of her injury of 13 October and the resulting period of immobility he recommended a trial of anti-inflammatories. He noted that Mrs A was worried about weight gain. Dr B found that she had gained 3kg in three months, but attributed this to her period of immobility and the course of prednisone prescribed for asthma control. He did not examine her abdomen at this visit. My expert advised that although Dr B could have been more thorough in his examination of Mrs A in relation to the thigh discomfort to rule out the possibility of venous thrombosis (blood clot), Mrs A's symptoms did not give clear indication of pelvic abnormality.

Ascites
I am advised that the diagnosis of ascites is not easy. It requires a high index of suspicion based on patient history, and a good examination of the abdomen. The clinical signs are unreliable and difficult to interpret. My advisor noted that although Dr E's notes of her examination of Mrs A on 27 November were detailed, they did not mention the detection of ascites. In my opinion, it is not reasonable to find that Dr B failed to meet professional standards in this respect.

In summary, in relation to the consultations of 11 August, 7 and 17 November 2000, and the failure to diagnose ascites, I consider that Dr B provided Mrs A with services with reasonable care and skill, in compliance with professional standards, and did not breach Rights 4(1) and 4(2) of the Code.

Other comments

Clinical notes
My expert noted that there is no record that Dr B followed up his initial examination of the cyst, and that he did not record whether the lump had settled or enlarged. My expert also commented that while it may have been a sebaceous cyst, it may have been a solid lesion or a secondary from Mrs A's cancer.

My advisor commented that Dr B recorded the findings of his examinations of Mrs A adequately, but that the quality of his patient symptom recording was less than adequate, and queried whether the notes truly reflected the consultations. He advised that it is important for a doctor, especially a general practitioner, to establish the patient's list of complaints and their expectations of the consultation. Time constraints and eliciting information from a patient can affect good communication. It appears that in relation to Dr B's management of Mrs A there was either inadequate exploration of her symptoms or inadequate recording.

Actions

I recommend that Dr B:

- Apologise in writing to Mrs A for his breaches of the Code. The apology should be sent to my Office and will be forwarded to Mrs A.
- Review his practice in light of this report.

Further actions

- A copy of this opinion will be sent to the Medical Council of New Zealand.
- A copy of this opinion, with identifying features removed, will be sent to the President of the Royal New Zealand College of General Practitioners, and will be placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.